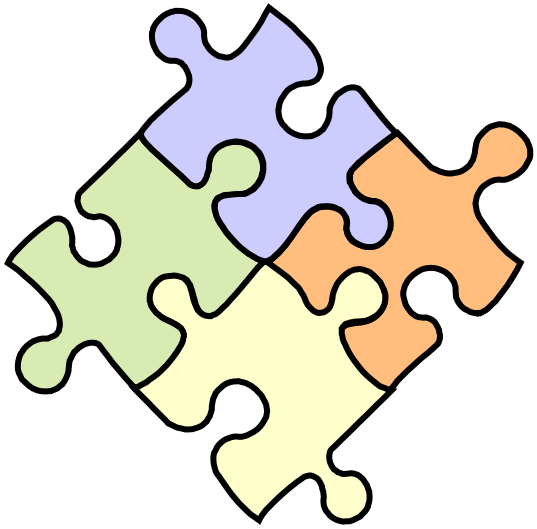
# Health Care Cost Drivers

Blue Ribbon Commission for Health Care Reform
Commission Retreat
January 31, 2007



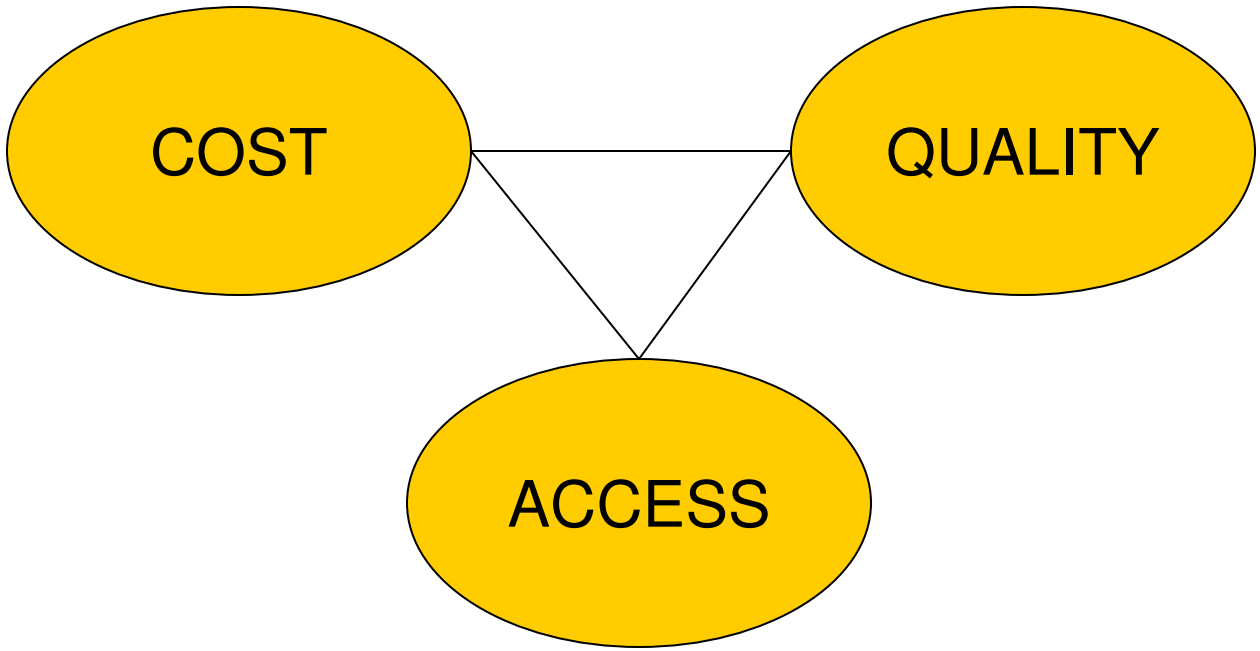
Presented by Leo Tokar

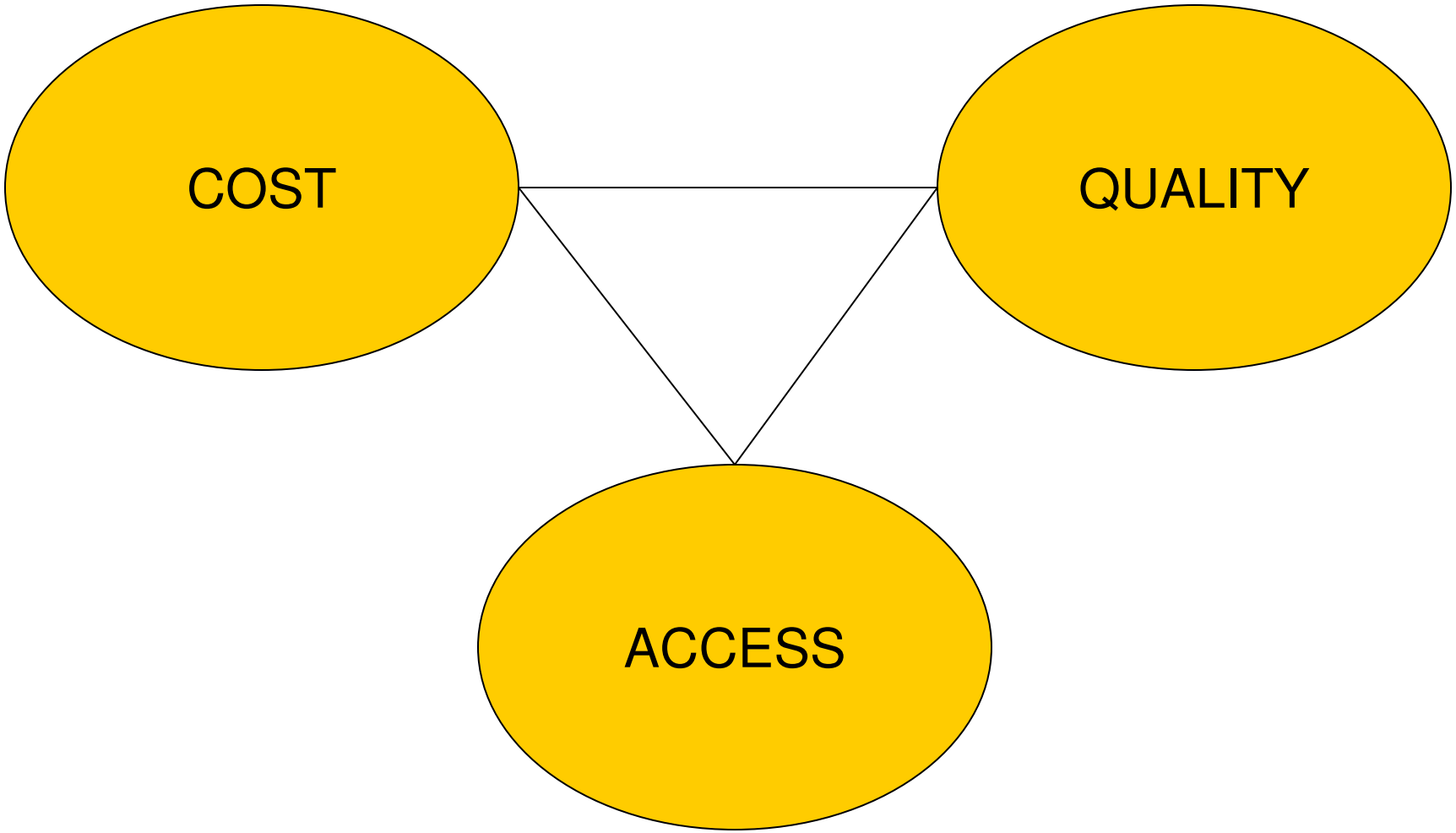
"Even small health care institutions are complex, barely manageable places… large health care institutions may be the most complex organizations in human history."

*- Peter Drucker*

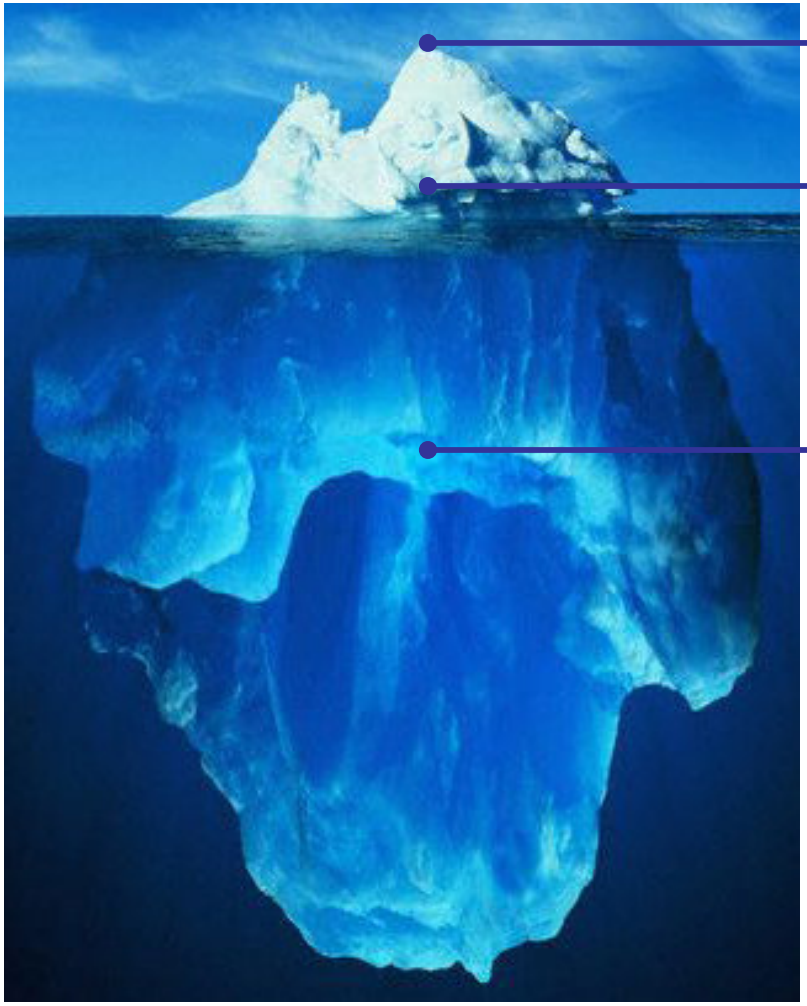
# Symptoms

- High ***costs*** & cost trends
- Poor ***access*** to health care & health insurance
- Underperforming ***quality***




COST
QUALITY
ACCESS

# Evaluation & Diagnosis



Cost spend (where the money goes)

Cost trend (how spend is increasing)

Cost drivers (why spend is increasing)

# Cost Spend


*see Appendix for breakdown

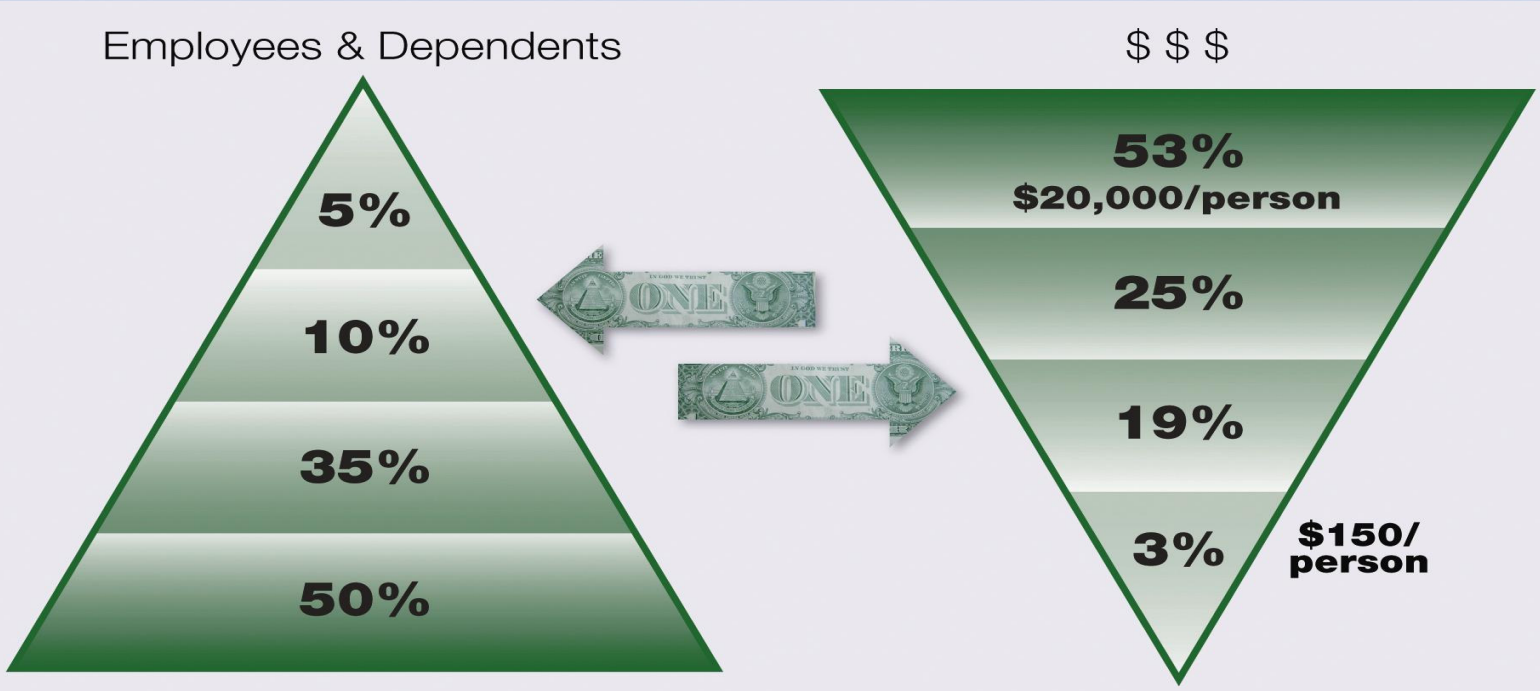
*Includes prevention, disease management, care coordination, investments in health information technologies and health support.
**Includes the inpatient costs of hospitals and the outpatient costs of hospitals and free-standing clinics.

Based on a PricewaterhouseCoopers' analysis, *Factors Fueling Rising Healthcare Costs 2006.*

© 2006 America's Health Insurance Plans

# Concentrations of Costs

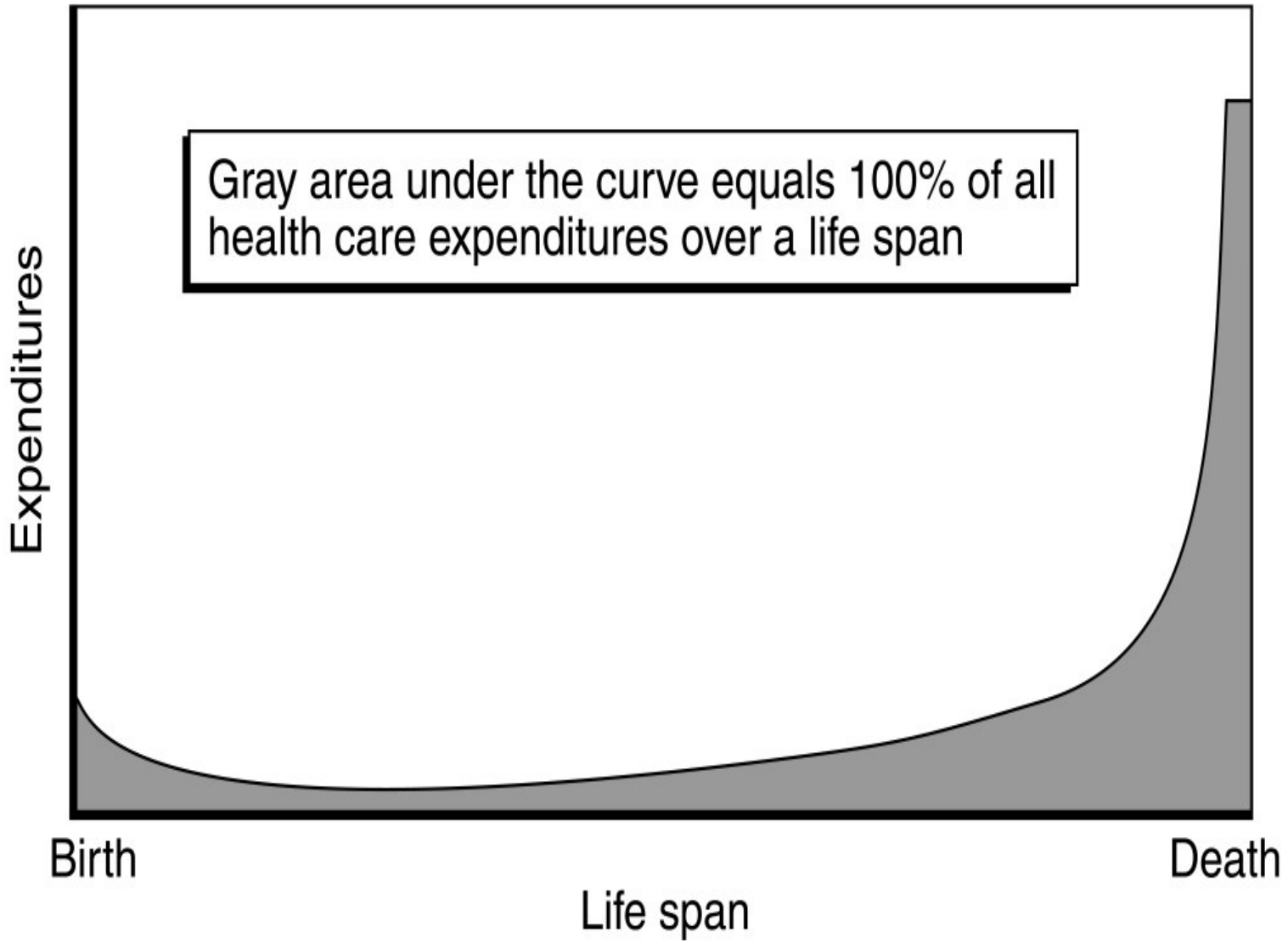
## 15% of People Account for Nearly 78% of Cost



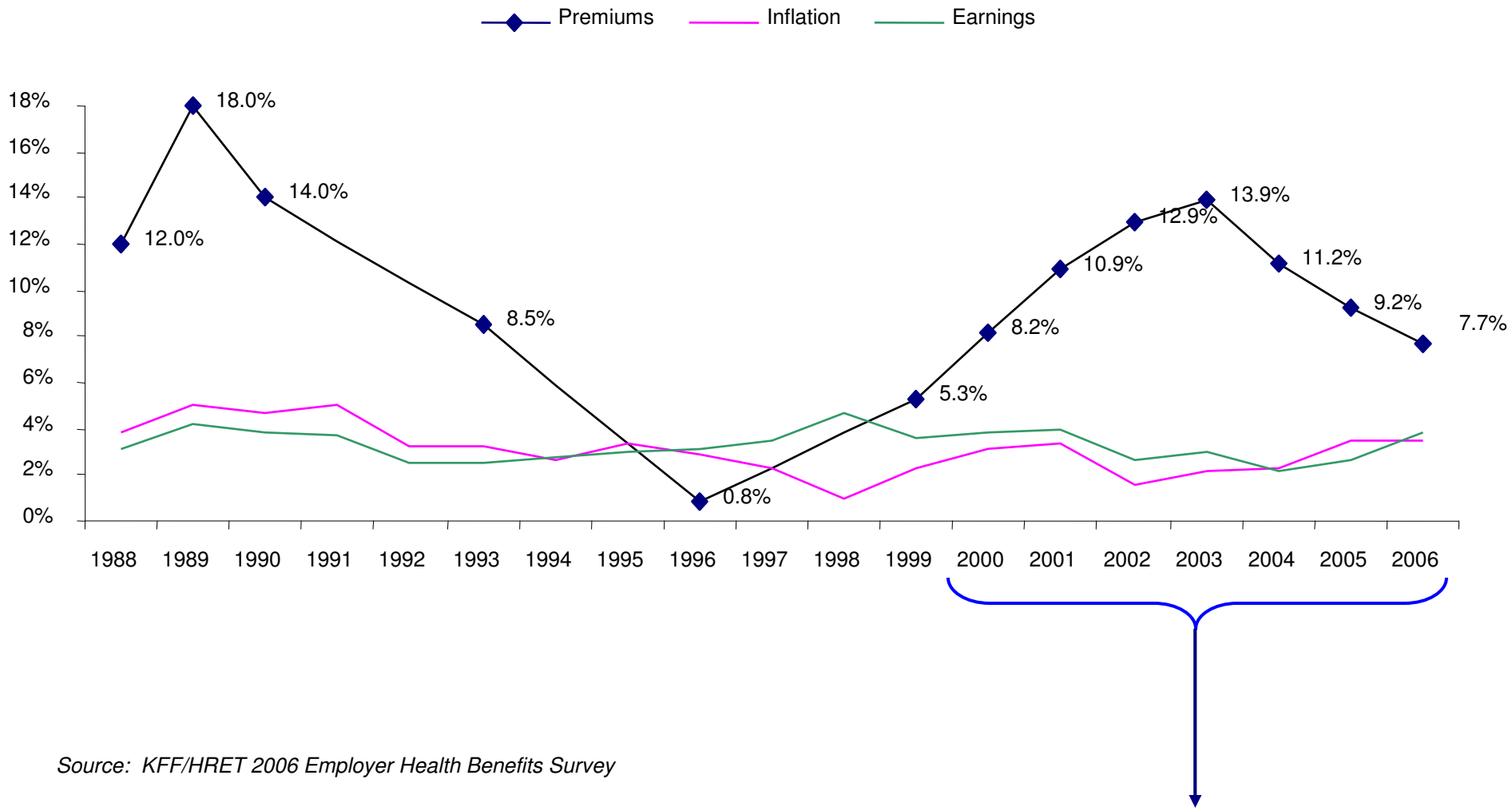

*Adapted from Mercer HR Consulting*

| | | | | |
|---|---|---|---|---|
| % of Employees | 5% | 10% | 35% | 50% |
| % of Claims | 53% | 25% | 19% | 3% |
| Average Claims/Employee | $20,000 | $5,000 | $1,000 | $150 |

# Concentrations of Costs

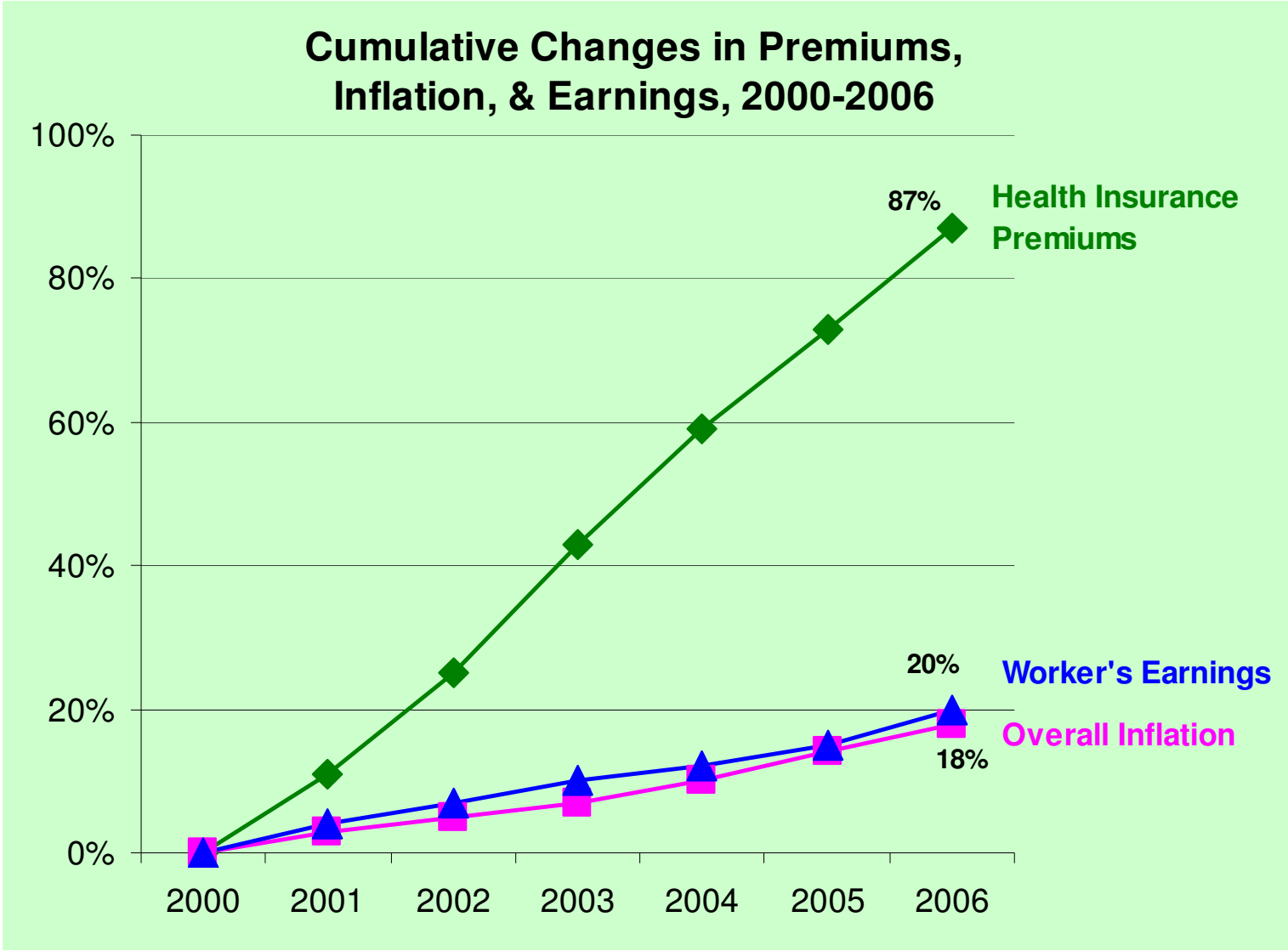


# Cost Trend




*Source: KFF/HRET 2006 Employer Health Benefits Survey*

# Cost Trend: a Personal View



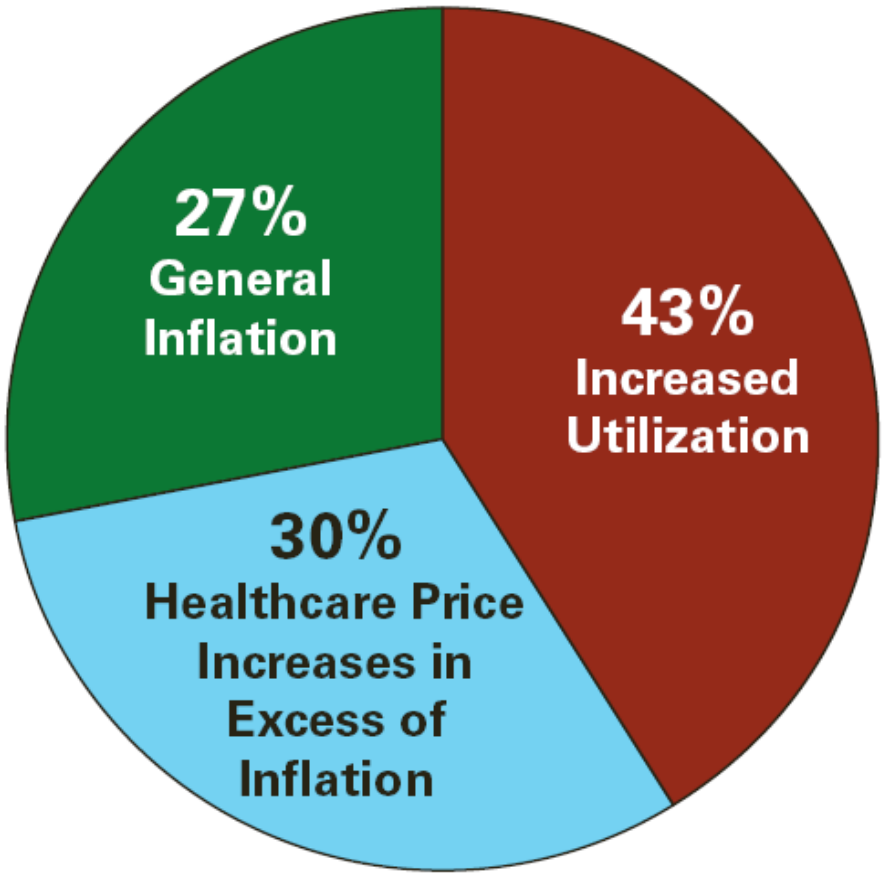

*Source: KFF/HRET 2006 Employer Health Benefits Survey*

# Cost Trend: Peeling the Onion

- Price: how much a unit costs
- Quantity: how many units you get
- Delivery: coordination across all units

# Cost Trend: a 2005 Snapshot

## Factors Contributing to the 8.8% Increase in Premiums




Source: The Factors Fueling Rising Healthcare Costs 2006, PriceWaterhouseCoopers

# Premium Increase Breakdown (2005)

| Components | Share | Total Share |
|---|---|---|
| **Total Premium** | **8.8%** | **8.8%** |
| General Inflation | 2.4% | 2.4% |
| Healthcare Price Increases in Excess of Inflation (Above CPI) | | 2.6% |
| Cost Shifting | 0.5% | |
| Higher Priced Technologies | 1.0% | |
| Broader-Access Plans/Provider Consolidation | 1.1% | |
| Increased Utilization | | 3.8% |
| Aging | 0.5% | |
| Lifestyle | 0.3% | |
| New Treatments | 1.0% | |
| More Intensive Diagnostic Testing/Defensive Medicine | 0.8% | |
| Increased Consumer Demand | 1.2% | |

Source: PricewaterhouseCoopers' estimates based on review of various studies and analyses.

# Growth in Premiums (04-05)

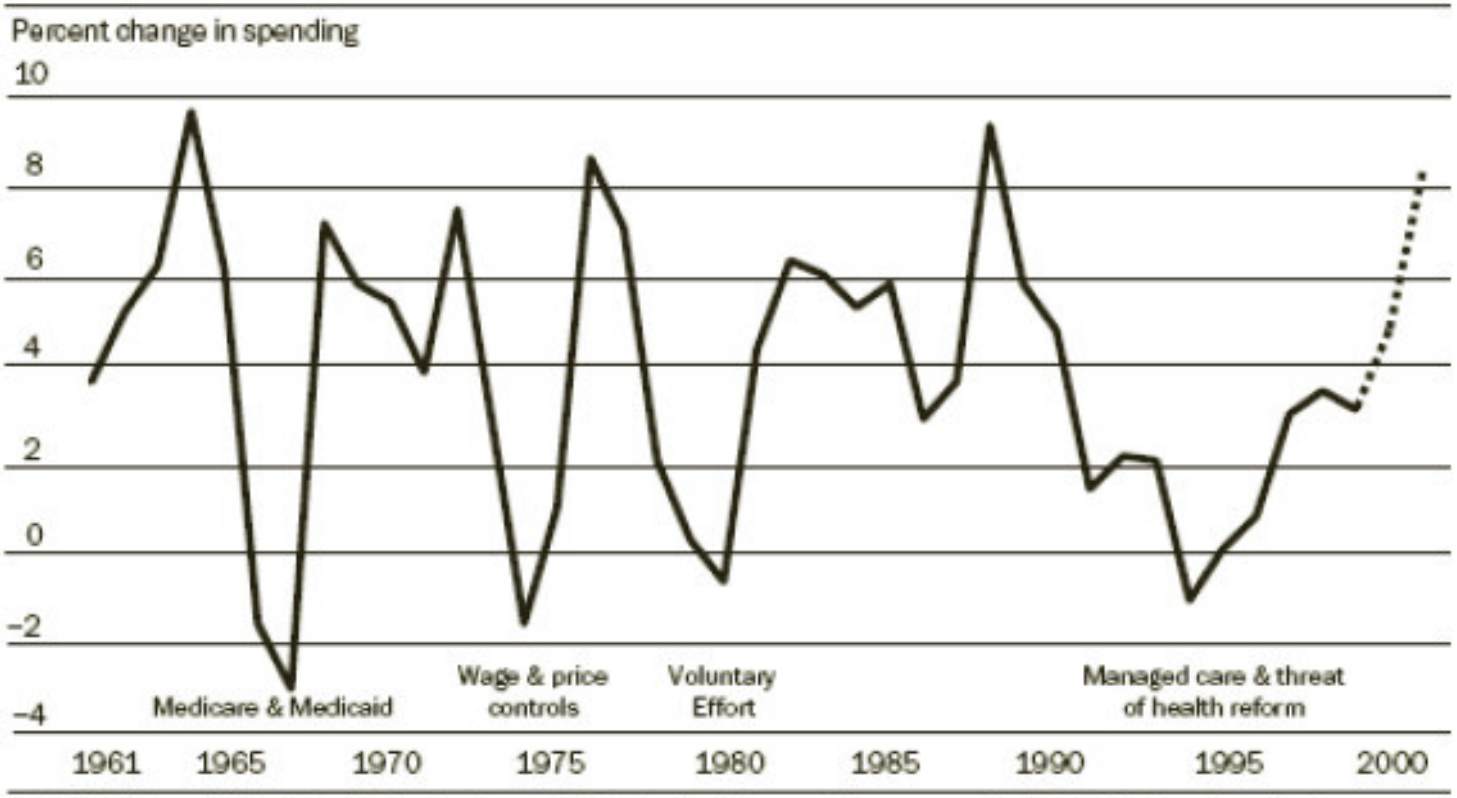
| Component | Share of Health Insurance Premium | Spending Growth Rate | Percentage Point Contribution to the 8.8% Increase in Health Insurance Premiums |
|---|---|---|---|
| *PHYSICIAN* | *24%* | *7.8%* | *1.9* |
| CPI | | 2.4% | 0.6 |
| Price Increase in Excess of Inflation | | 2.3% | 0.6 |
| Utilization | | 3.1% | 0.7 |
| *OUTPATIENT* | *22%* | *13.6%* | *3.0* |
| CPI | | 2.4% | 0.5 |
| Price Increase in Excess of Inflation | | 4.0% | 0.9 |
| Utilization | | 7.2% | 1.6 |
| *HOSPITAL INPATIENT* | *18%* | *7.5%* | *1.3* |
| CPI | | 2.4% | 0.4 |
| Price Increase in Excess of Inflation | | 4.0% | 0.7 |
| Utilization | | 1.1% | 0.2 |
| *PRESCRIPTION DRUGS* | *16%* | *8.6%* | *1.4* |
| CPI | | 2.4% | 0.4 |
| Price Increase in Excess of Inflation | | 1.1% | 0.2 |
| Utilization | | 5.1% | 0.8 |
| *OTHER MEDICAL SERVICES* | *6%* | *7.3%* | *0.4* |
| CPI | | 2.3% | 0.1 |
| Price Increase in Excess of Inflation | | 2.6% | 0.2 |
| Utilization | | 2.4% | 0.1 |

Source: PricewaterhouseCoopers calculations, December 2005.
Contribution to the 8.8 percent increase is derived by multiplying the component's share of current spending by its growth rate.

# Few Quick Fixes

**EXHIBIT 1**

**Annual Change In Private Health Spending Per Capita (Adjusted For Inflation), 1961–2001**




**SOURCES:** Henry J. Kaiser Family Foundation analysis. Private health expenditures per capita, 1960–1999, are from the Centers for Medicare and Medicaid Services (CMS). Change in private spending per capita, 2000–2001, is estimated based on average premium increases for employer-sponsored coverage from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits.
**NOTES:** Real change in spending is calculated using the Consumer Price Index (CPI-U) all items, average annual change for 1961–2000 and July-to-July change for 2001. This analysis was inspired by an analysis done by Jeff Merrill and Richard Wassermann more than fifteen years ago. See J.C. Merrill and R.J. Wassermann, "Growth in National Expenditures: Additional Analyses," *Health Affairs* (Winter 1985): 91–98.

"The prevailing model of health care delivery is complicated, comprising layers of processes and handoffs that patients and families find bewildering and clinicians view as wasteful."

"Our current methods of organizing and delivering care are unable to meet the expectations of patients and their families because the science and technologies involved in health care – the knowledge, skills, care interventions, devices, drugs – have advanced more rapidly than our ability to deliver them safely, effectively, and efficiently"

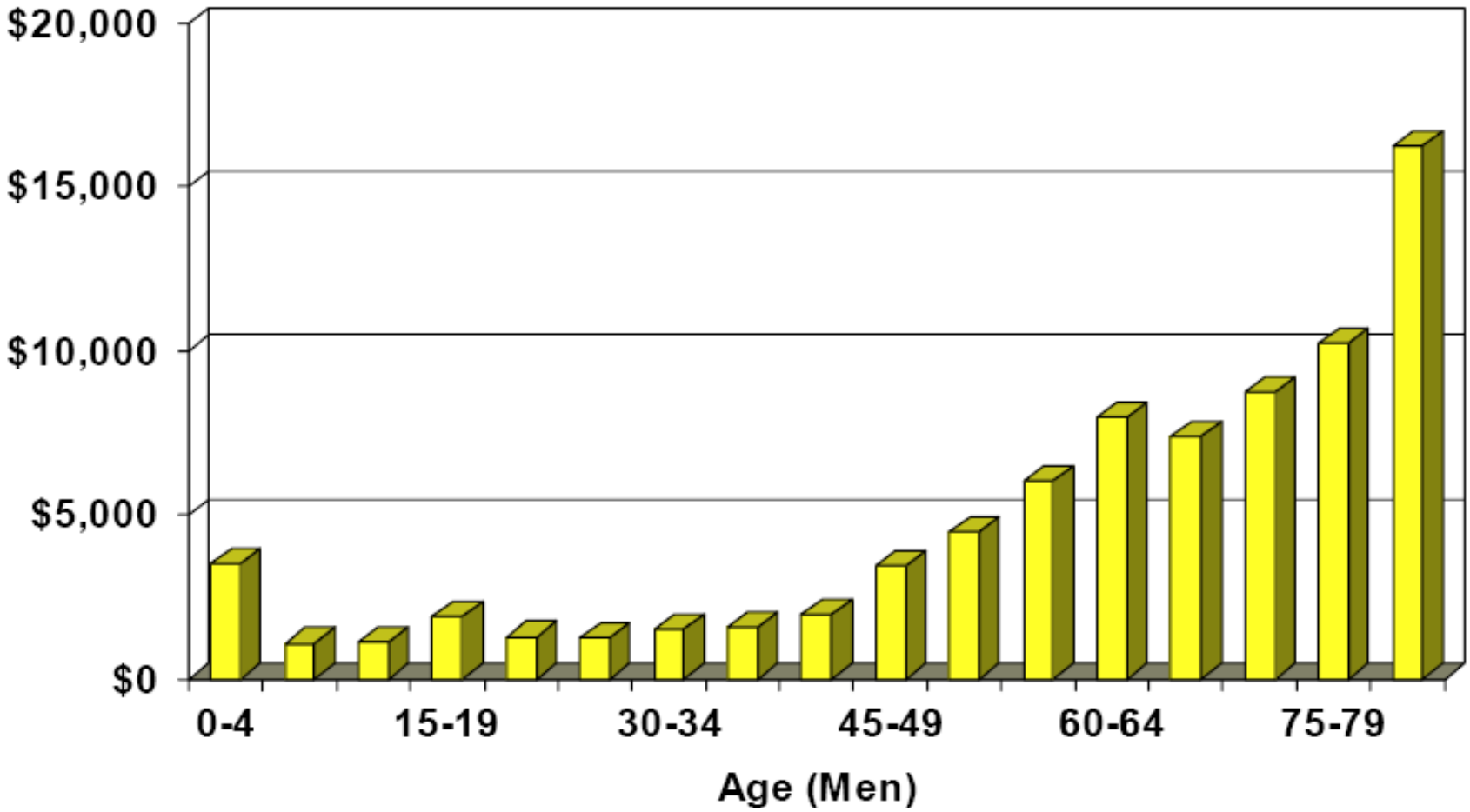
Institute of Medicine Report: "Crossing the Quality Chasm"

# Cost Drivers: (some) Root Causes

In no particular order,

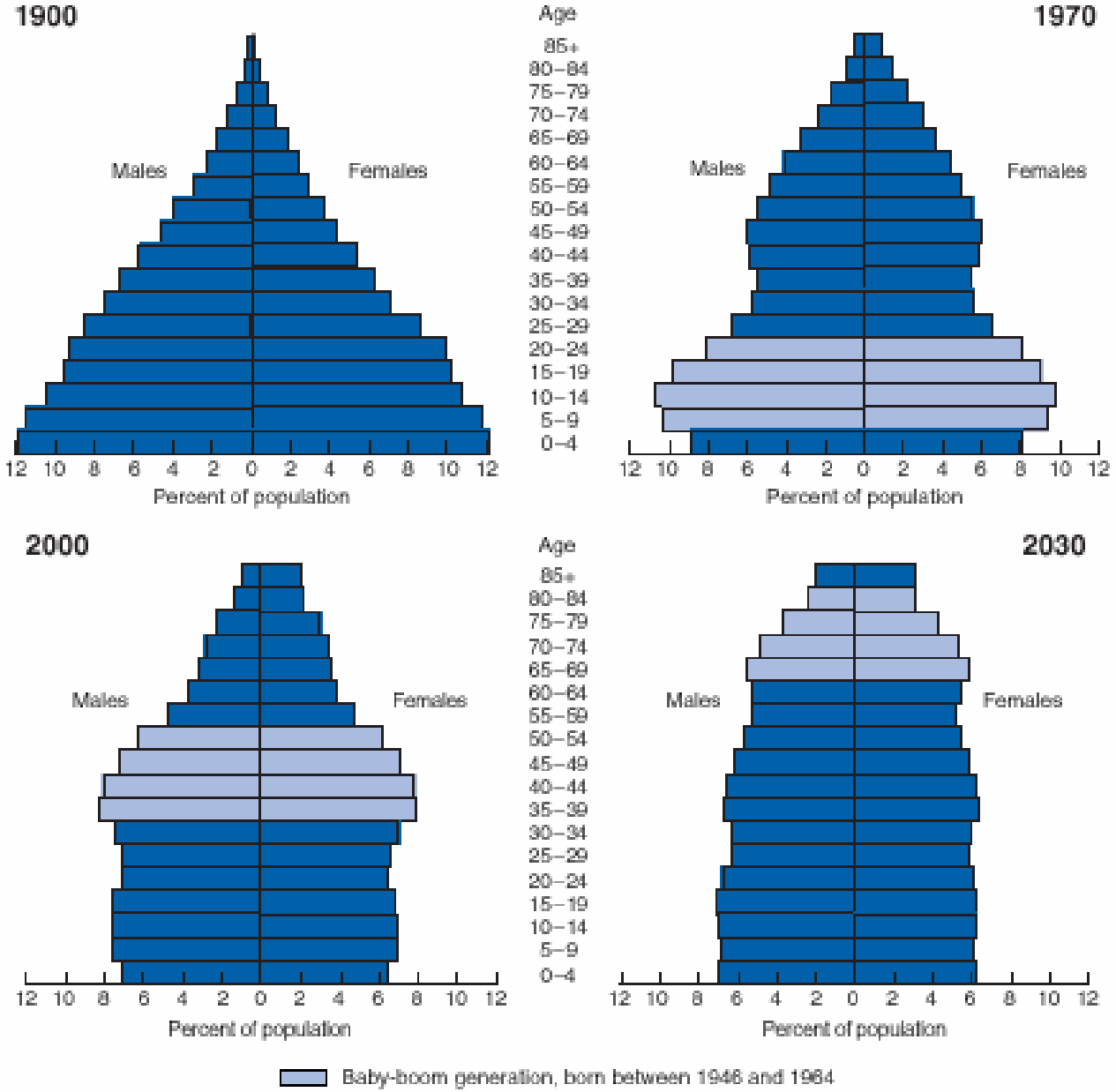
- Aging population
- Medical technology
- Moral hazard (insurance)
- Cost shifting (public-private)
- Uninsured
- Administrative inefficiencies
- Health care delivery inefficiencies
- Legal environment
- No true system

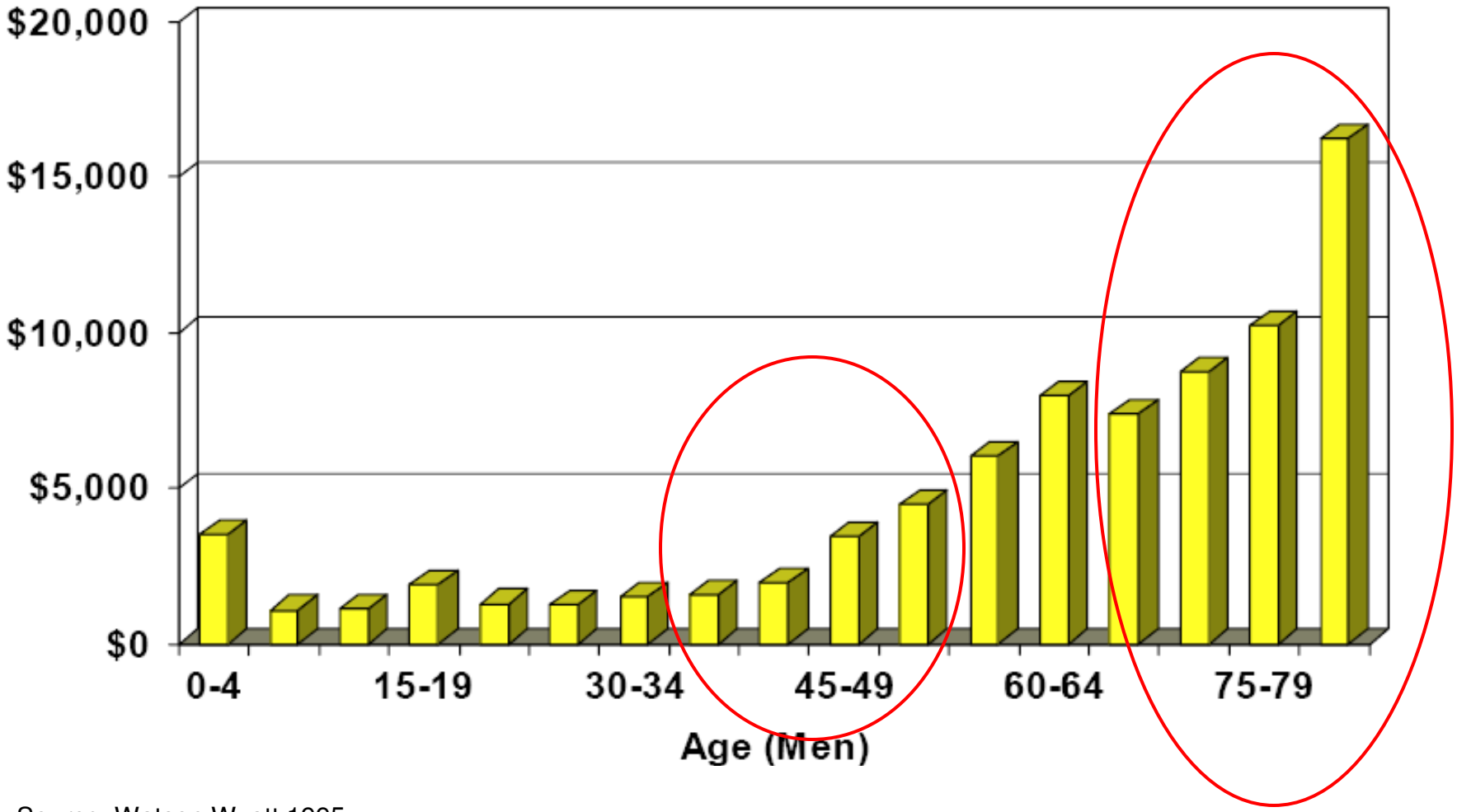
# Aging




Source: Watson Wyatt 1995

# The Fattening of America's Demographic






Source: Watson Wyatt 1995

# Medical Technology

"It is commonly accepted that advances in technology have been one of the most important, if not the single most important, driver of health care spending growth over the past several decades."

- Analysis Group

**Hip replacement**

… 40 years ago

- x-ray, a few aspirin, a cane

  Cost: $100

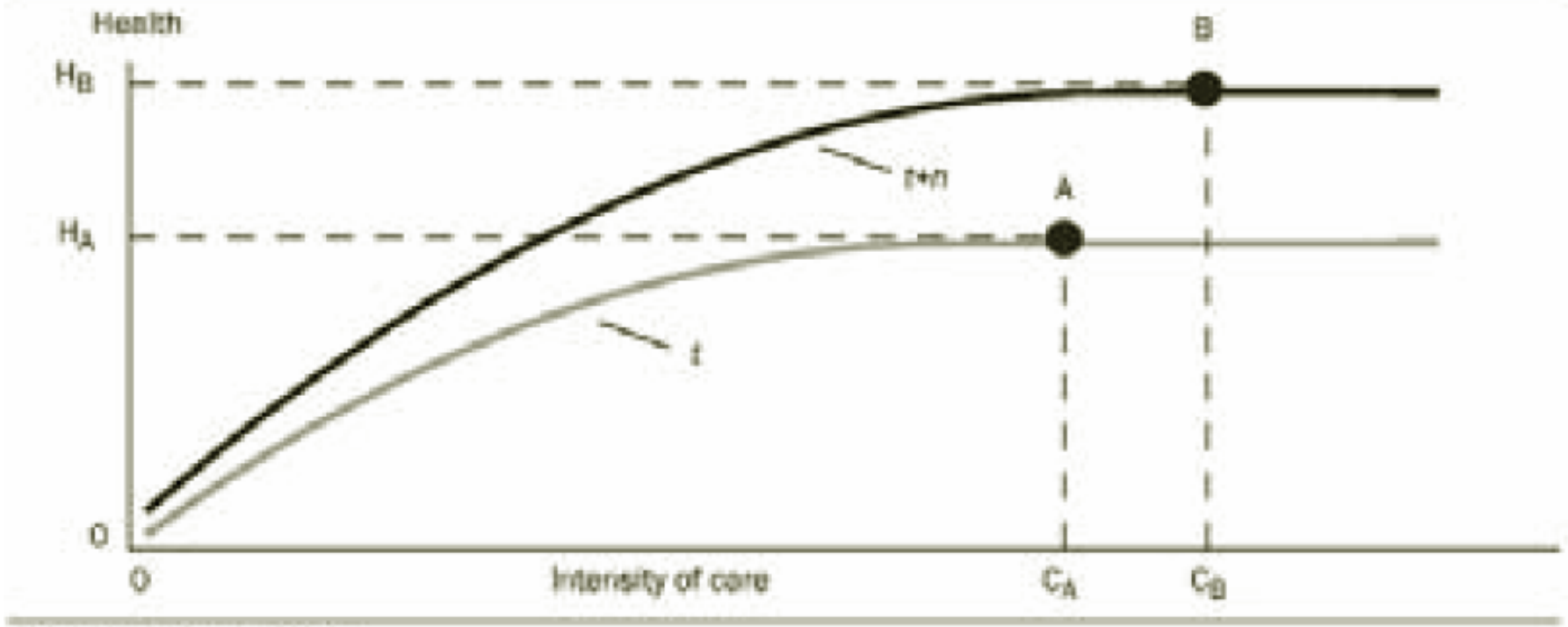
… Now

- MRI, hip replacement, physical therapy, a few aspirin, and a cane

  Cost: Priceless (or ~$40,000)

# Medical Technology

**Relationship Between Health And Intensity Of Care**




**SOURCE:** Author's analysis

Source: "More Variation in the Use of Care, More Flat-of-the-Curve Medicine", Fuchs, V.R., *Health Affairs*, October 2004, p. 105.

# Medical Technology

- Technology accounts for >50% of the rise in health care costs
- Increases in technology availability = increases in utilization and spending on the technology
- 10 percent increase in the surgeon/population ratio results in about a 3 percent increase in per capita utilization
  - Fees increase when the surgeon/population ratio increases
- Adding an extra year of life for the elderly cost $145,000

… but that's not the whole story


Sources: RAND 1987 study

Final Report on the Relationship Between Technology Availability and Health Care Spending, Analysis Group November 3, 2003

Fuchs, V. R. (1978). "The supply of surgeons and the demand for operations." Journal of Human Resources 13(suppl): 35-56.

Cutler, David M., Allison B. Rosen, Sandeep Vijan, The Value of Medical Spending in the United States, 1960–2000, New England Journal of Medicine, Volume 355:920-927, August 31, 2006.

# Moral Hazard

"the possibility that the redistribution of risk changes people's behavior, such as where coverage against a loss might increase the risk-taking behavior of the insured "

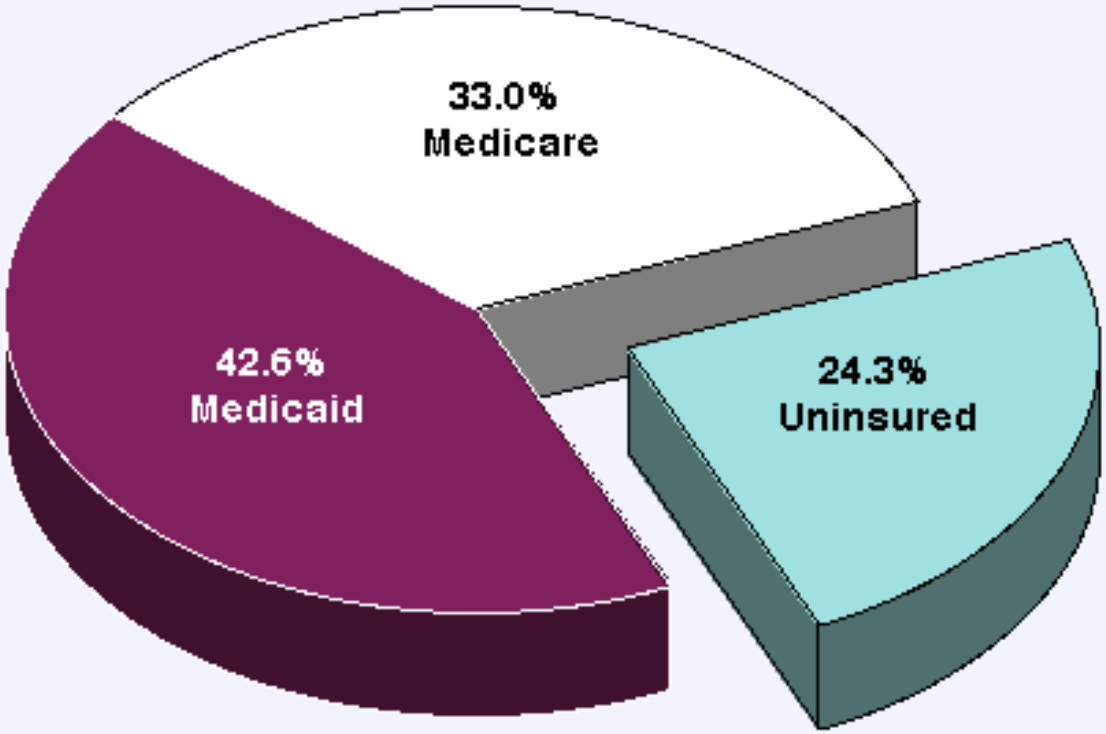
- Moral hazard and technology: cause and effect
- Impact of Medicare on hospital spending:  6x vs. individual-level insurance changes
  - hospitals incented to incur fixed costs of market entry or adopt new practice styles.
- Spread of health insurance 1950-1990 explains 1/2 of the increase in per capita health spending
- Challenge: can Americans take "no" for an answer?

Source: Finkelstein, Amy. The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare, *Quarterly Journal of Economics.* February 2007

# Cost-shifting

## Source of Uncompensated Health Care

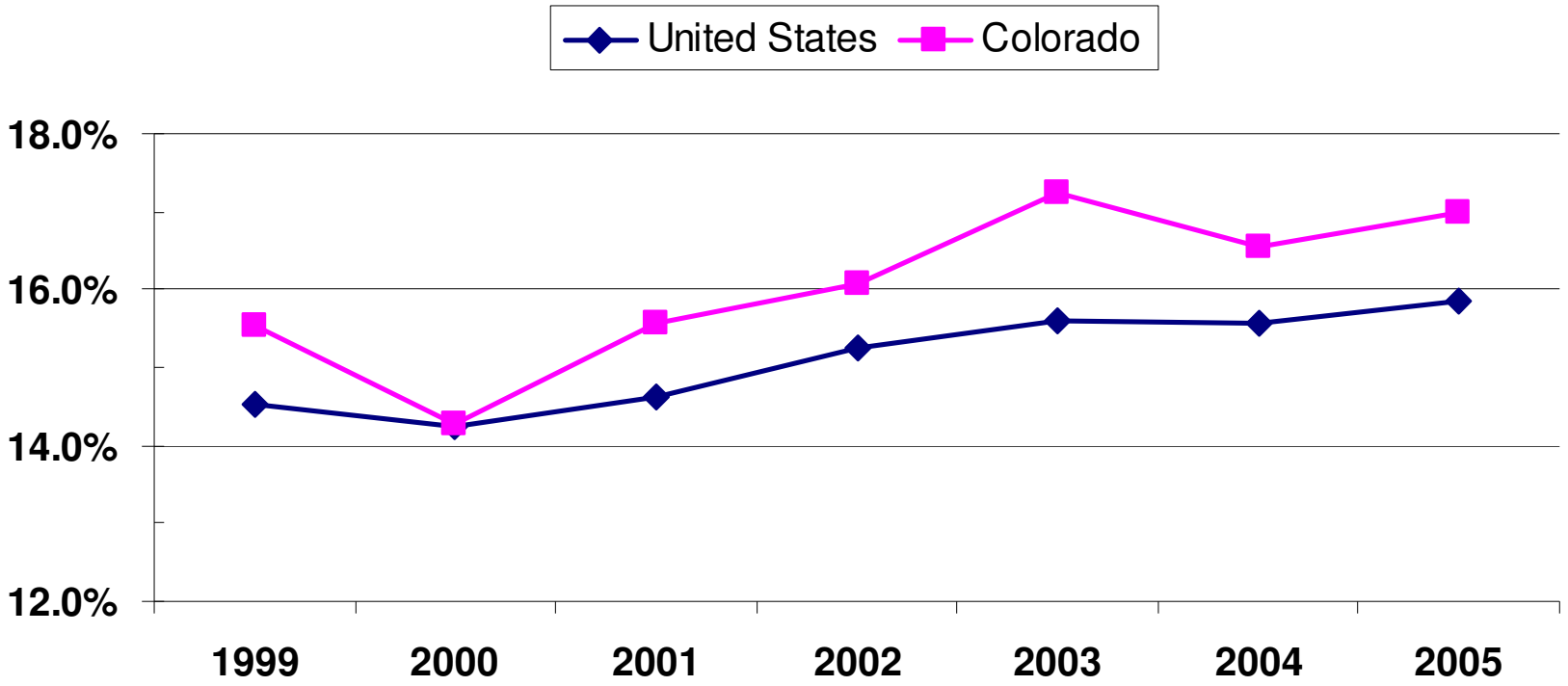
(1995)




Source: Projection based on Sandra Christensen, *CBO Staff Memorandum: Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates*, (Washington, DC: Congressional Budget Office, April 1993).

# The Uninsured

## Percent Uninsured, U.S. and Colorado: 1999-2005




- Uninsured pay ~30% of the health care they receive (source: CBO)
- "Pooling of interests" theory breaks downs
- 5-10% gain from bringing the uninsured into the market (est)

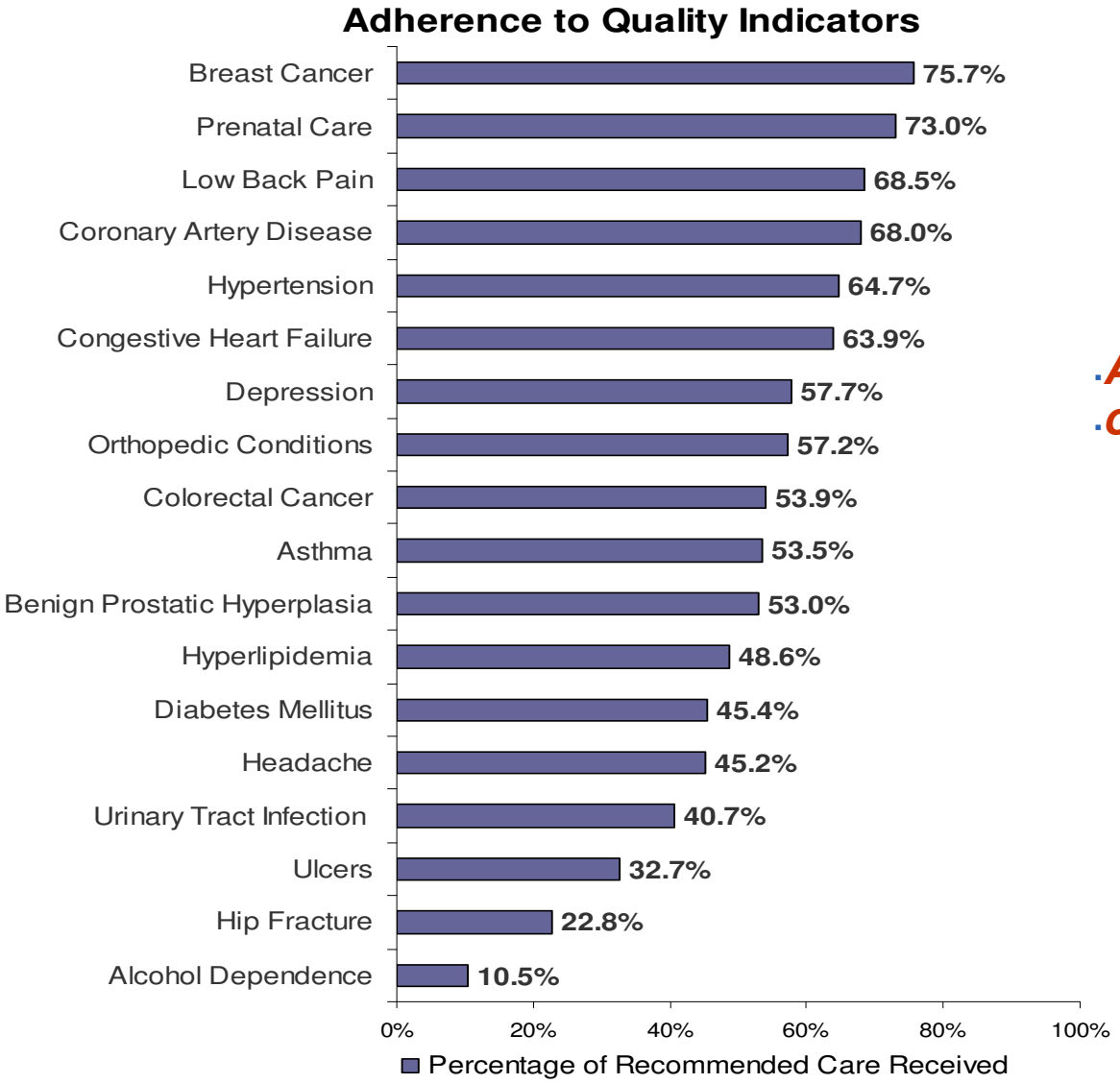
# Administrative Inefficiencies

Administrative costs of insurers, hospitals, doctors, nursing homes and other institutions:

- US: $399 billion (20%) per year on health care bureaucracy
  - Estimates range from 19-24%
- CA: 28% went to administration

Source: http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2004/10/11/MNGII96CVP1.DTL (reference Harvard Medical School research)

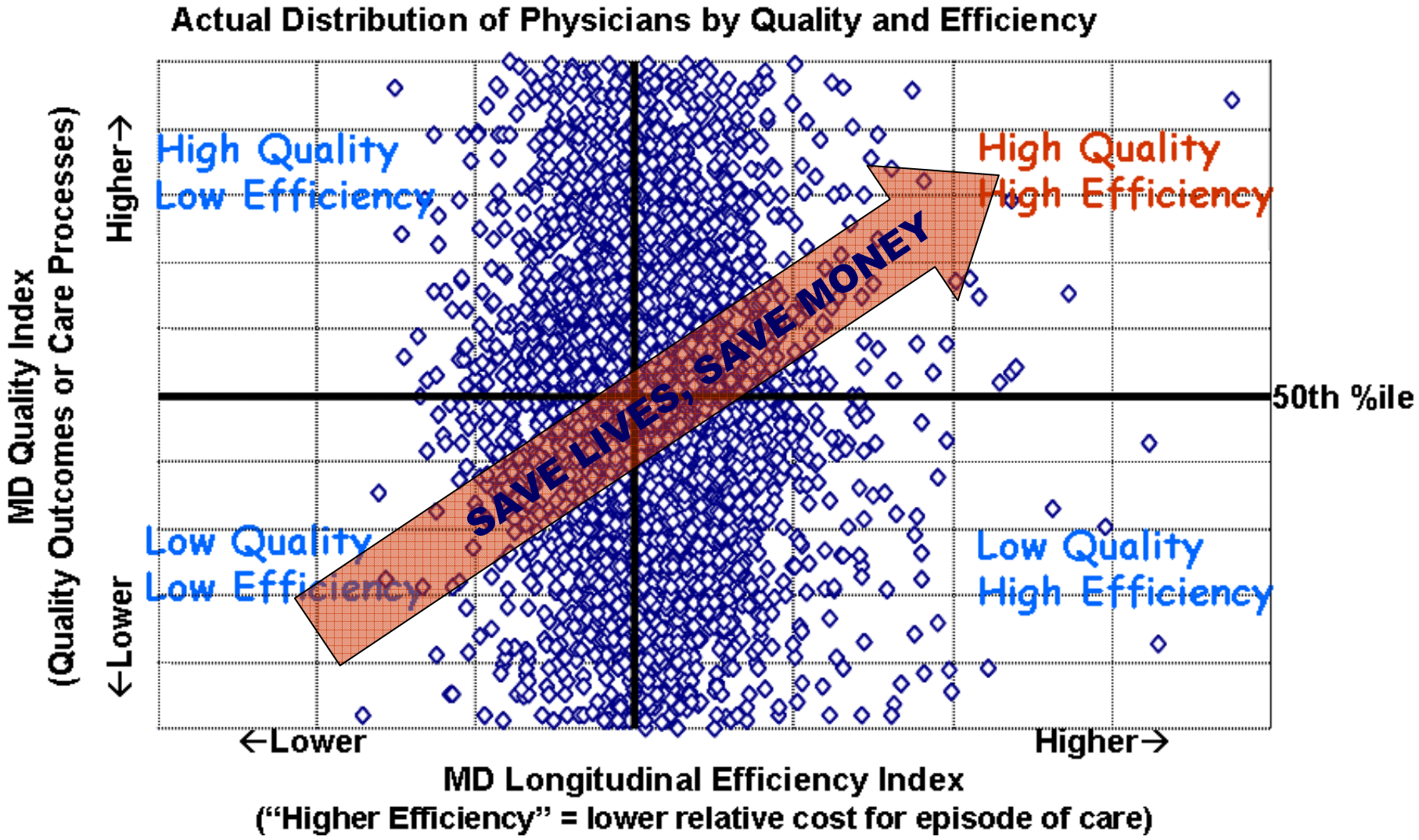
# Getting it Quality 50% of the Time




- ***Adults receive about half***
- ***of recommended care***
  - ***54.9% = Overall care***
  - ***54.9% = Preventive care***
  - ***53.5% = Acute care***
  - ***56.1% = Chronic care***

Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645

# Not All Quality is Created Equally




Adapted from Regence Blue Shield

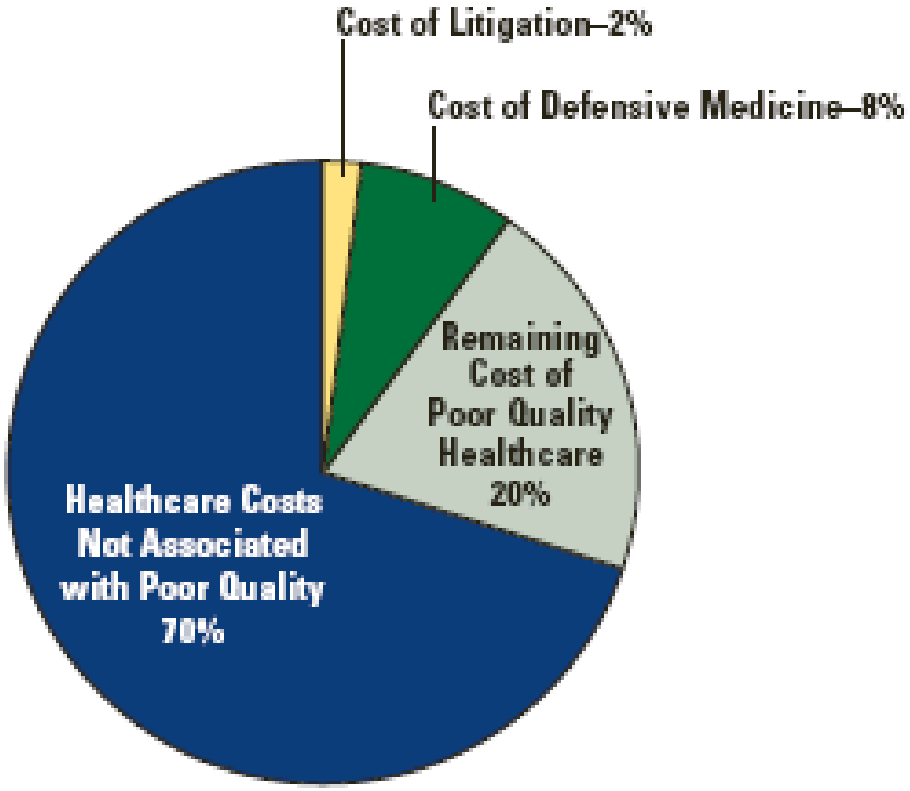
# Legal Environment

| Cost of Medical Liability and Defensive Medicine as a Share of the Premium Dollar, 2005 | | | |
|---|---|---|---|
| **Component** | **Total Share of Premium** | **Medical Liability Share of the Premium Cost** | **Benefit Share of Premium Less Medical Liability** |
| Physician | 24% | 3% | 21% |
| Outpatient | 22% | 4% | 18% |
| Hospital Inpatient | 18% | 1% | 17% |
| Prescription Drugs | 16% | 1% | 15% |
| Other Medical Services | 6% | 1% | 5% |
| **Total** | **86%** | **10%** | **76%** |

Source: PricewaterhouseCoopers' estimates, December 2005.

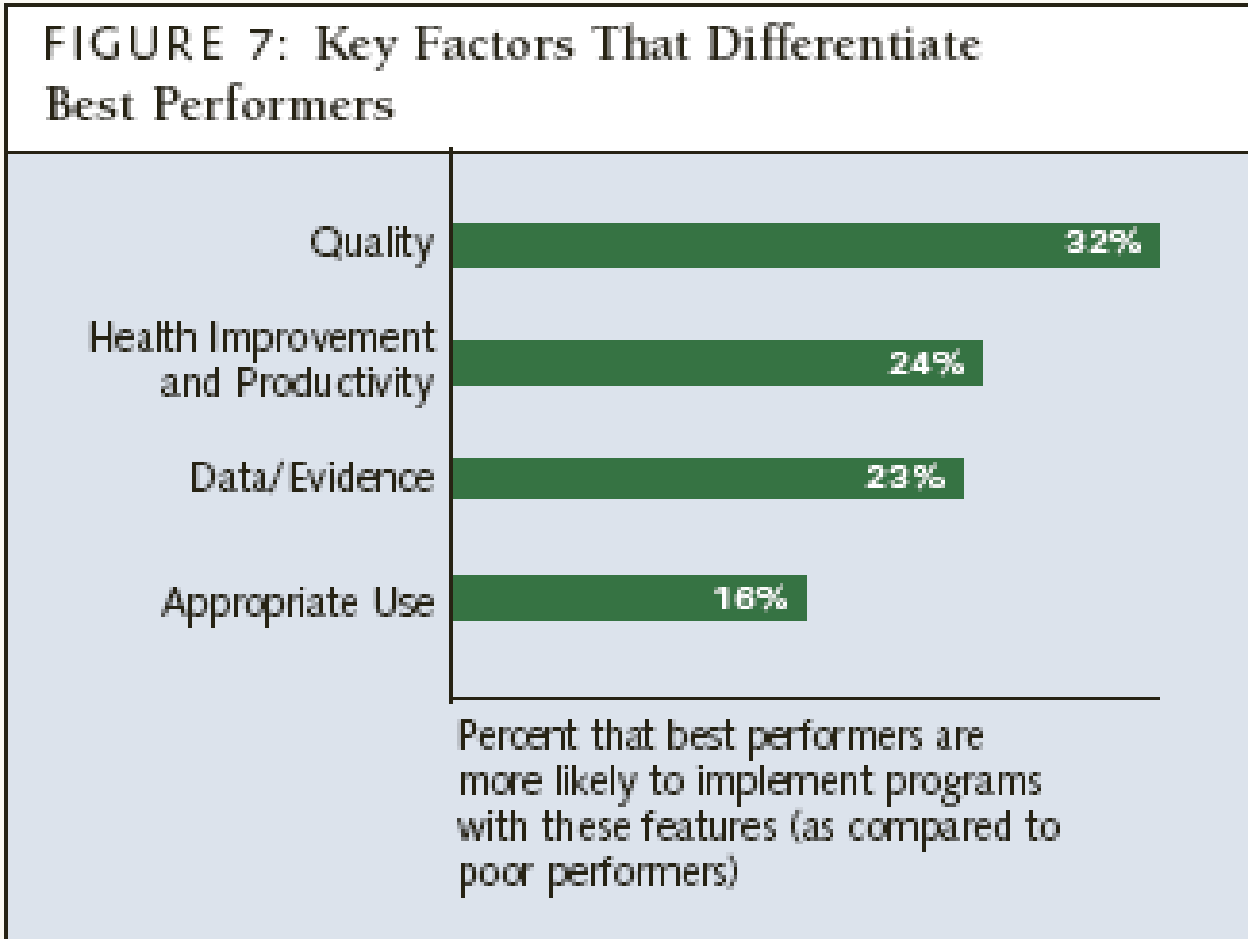
# Cost of Poor Quality

## Estimated Breakout of Healthcare Costs of Poor Quality




Source: This graphic is based on the Juran Institute, Inc. and The Severyn Group Inc, "Reducing the Costs of Poor Quality Health Care Through Responsible Purchasing Leadership." April 2003.

# Employer Quality Initiatives

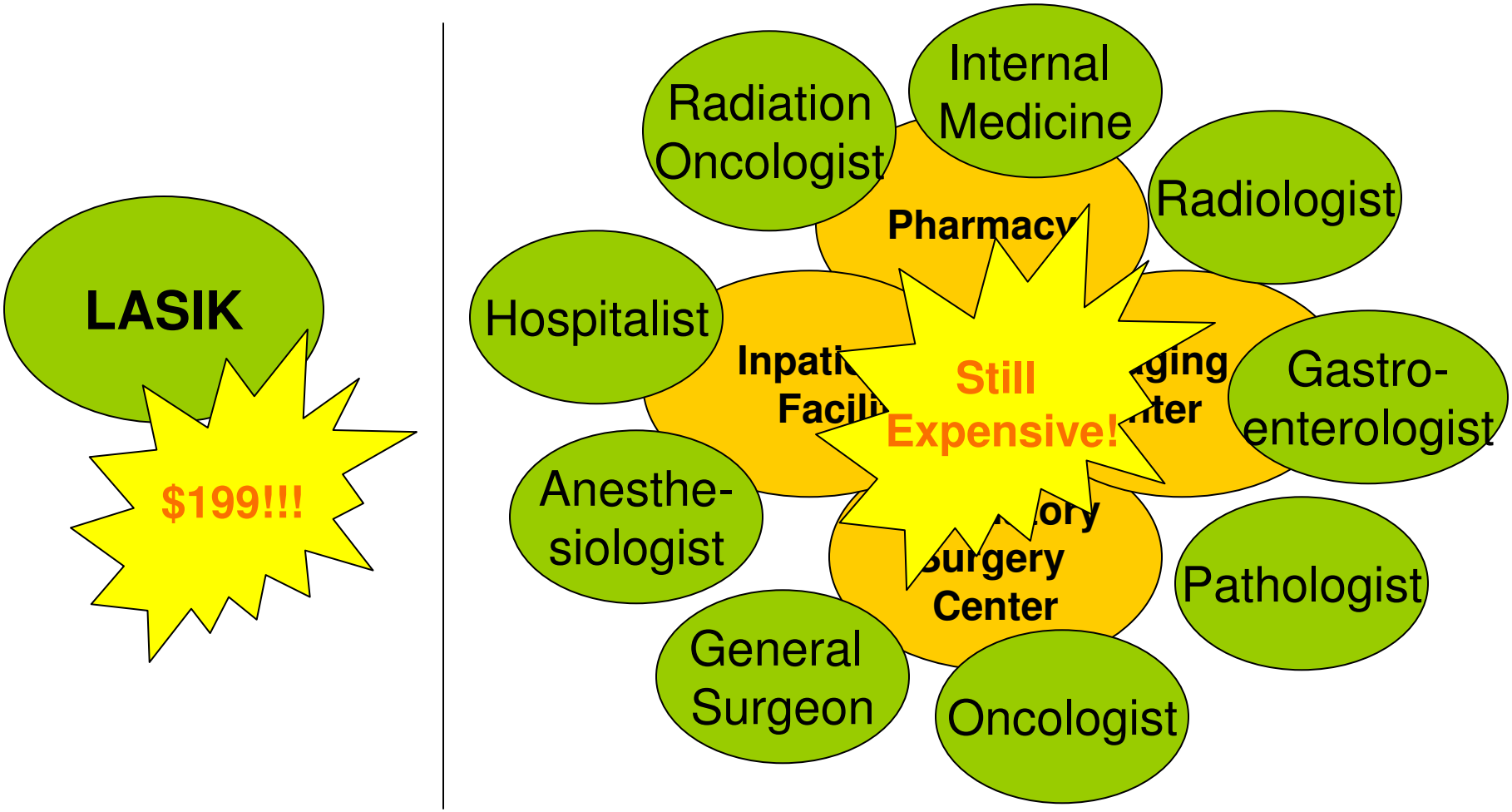



Source: Delivering on Health Care Consumerism: Strategies for Employer Success, 11th Annual National Business Group on Health/ Watson Wyatt Survey Report, 2006

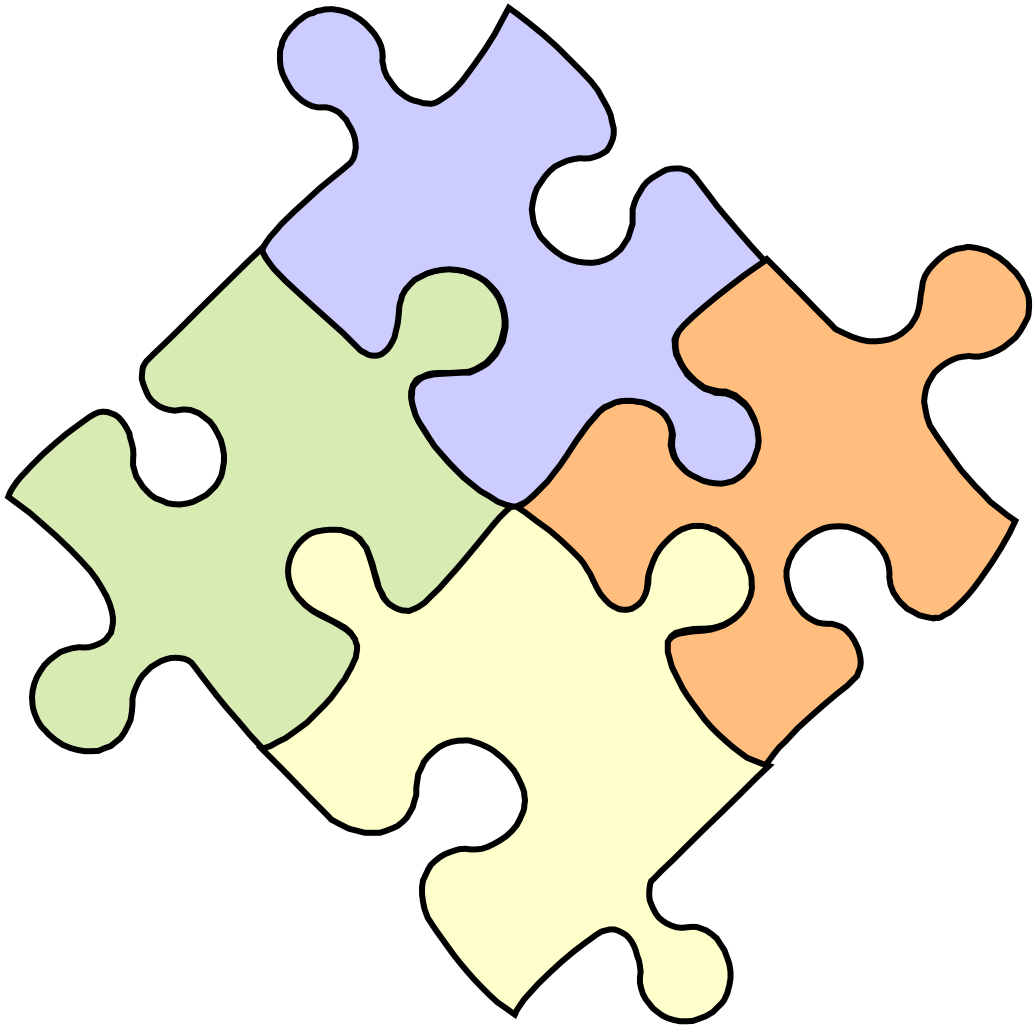
# Recap

- Costs concentrated with a few people, and in particular stages of life
- Costs *trends* are concentrated in high intensity, high technology services
- Aging and lifestyle exacerbating costs
- Cost shifting occurring due to uninsured & underinsured, public programs
- The insurance system lacks pooling of interests, pushes moral hazard
- Consumer detached from true cost of health care
- Health care lacks of data, standards, processes and feedback mechanism
- Proliferation of technology, medications, and procedures without strong evidence
- Strong focus on individual rights (vs. community rights)

# Retail meets “System-ness”

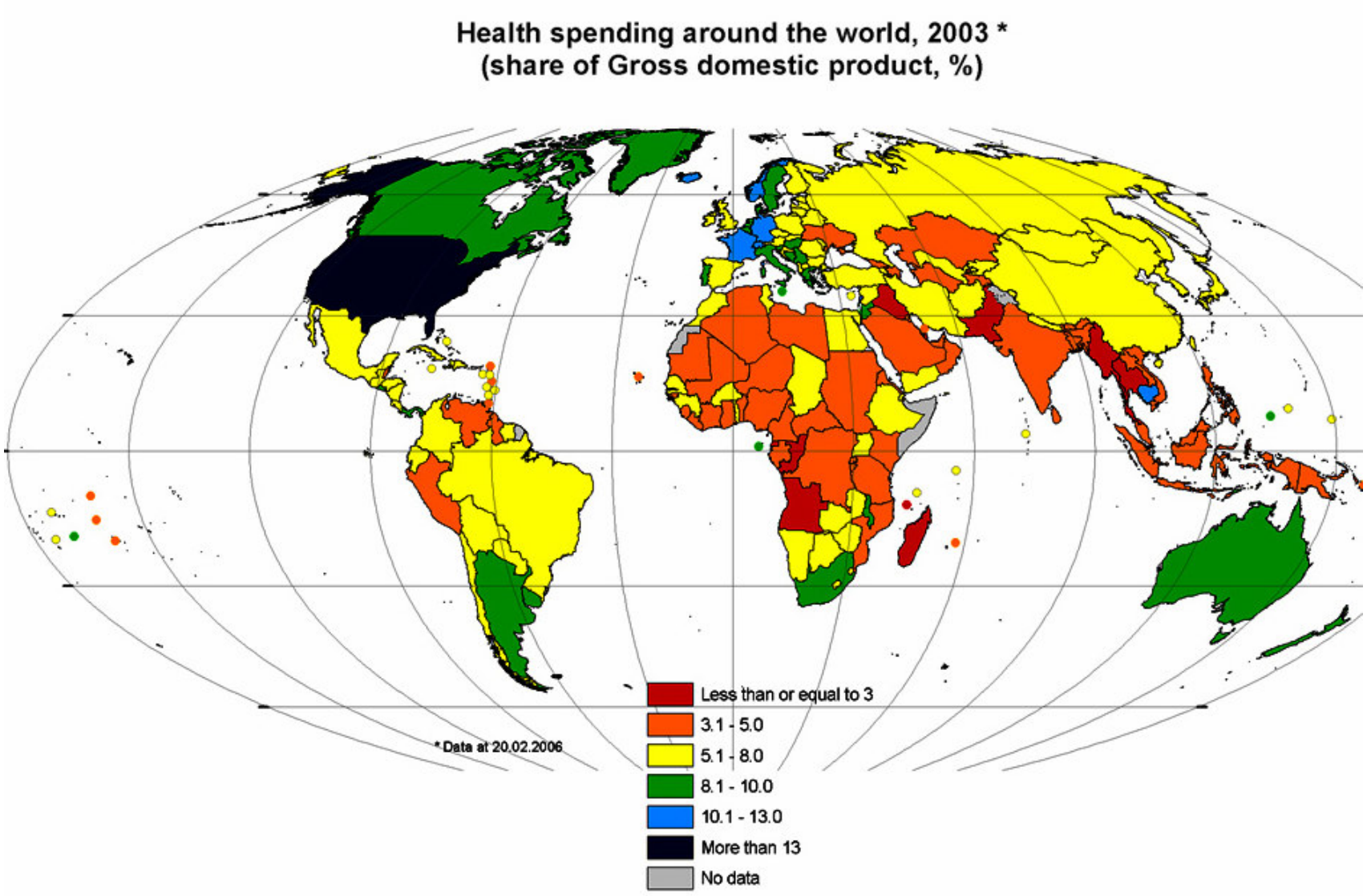


# A Different View of Health Care



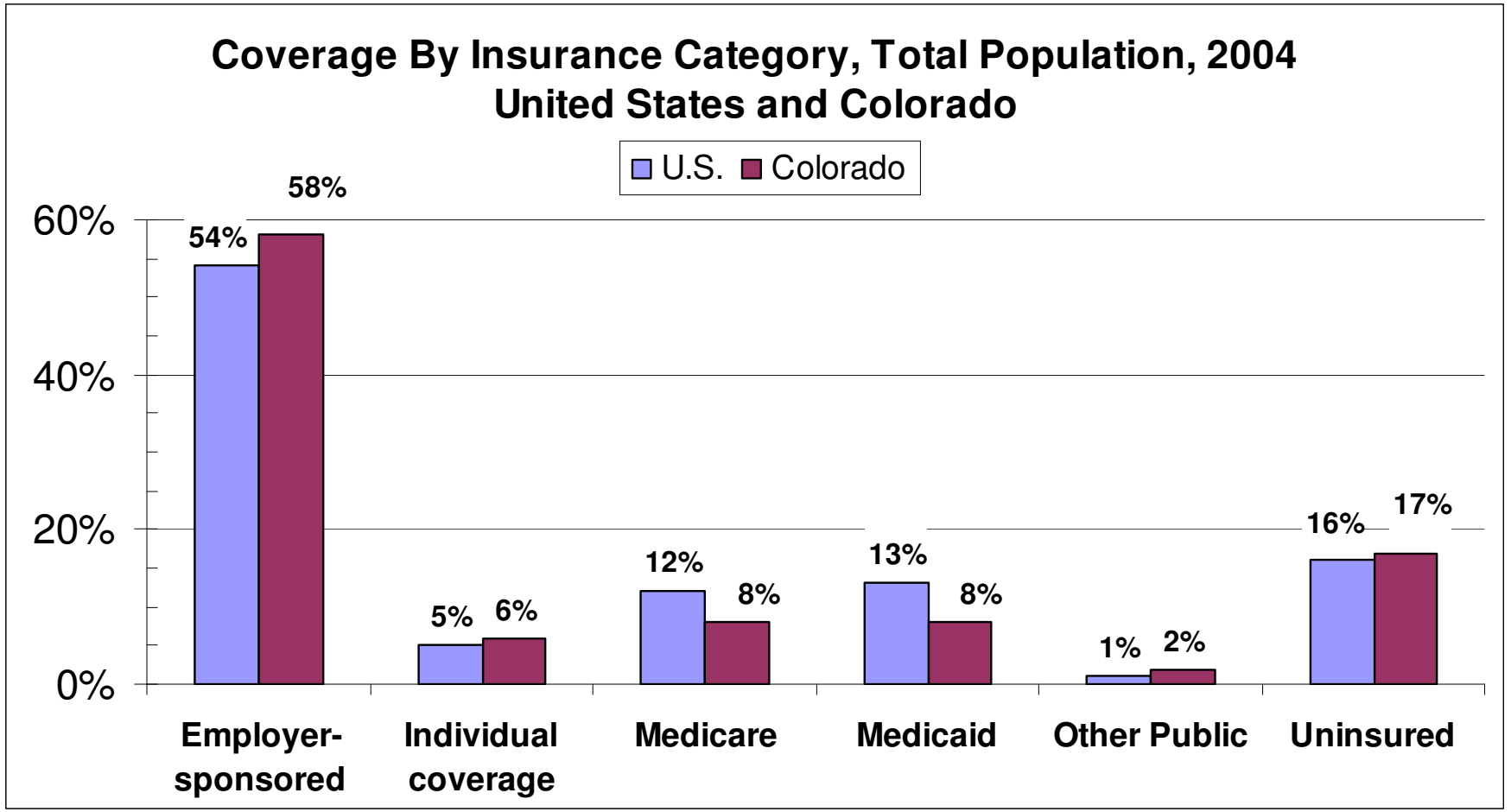
# Appendix

# First but not Best




*Source: World Health Organization (WHO)*

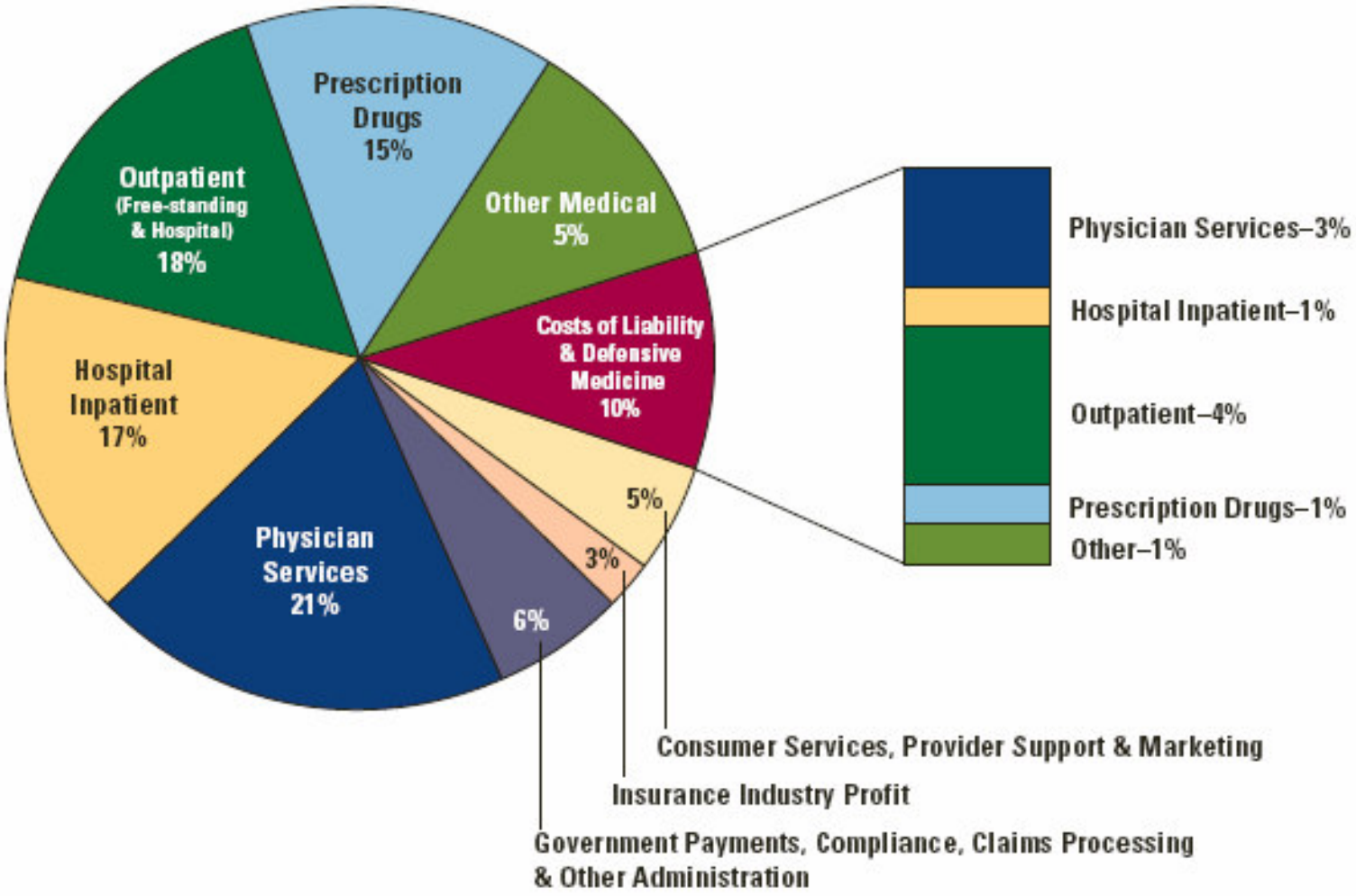
# Colorado vs. US



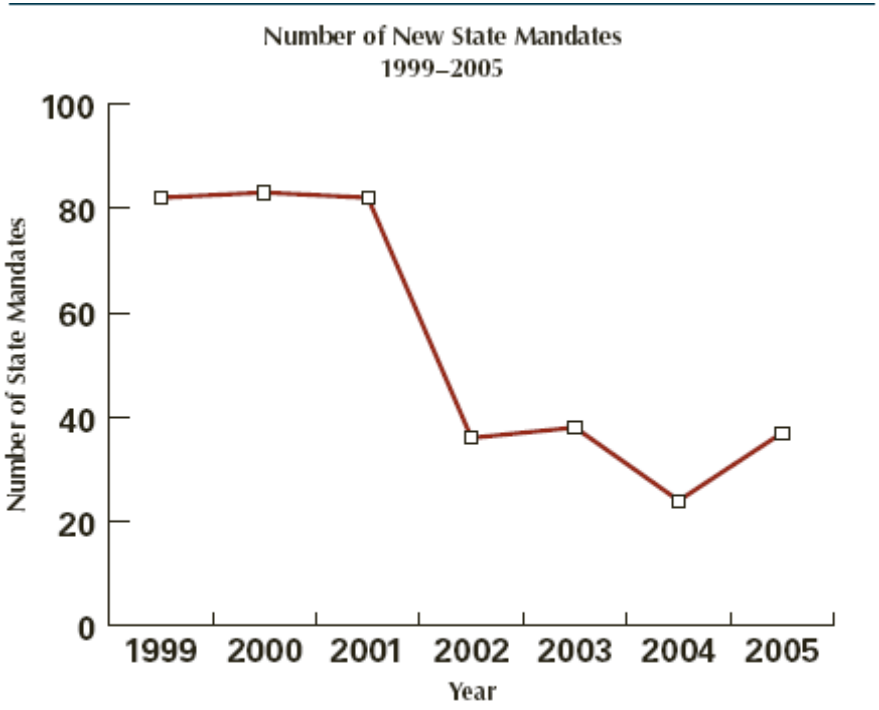

*Source: Kaiser Family Foundation, Statehealthfacts.org*

# Medical Liability and Defensive Medicine

Estimated Breakdown of Insurance Premiums With Medical Liability and Defensive Medicine Extracted, 2005

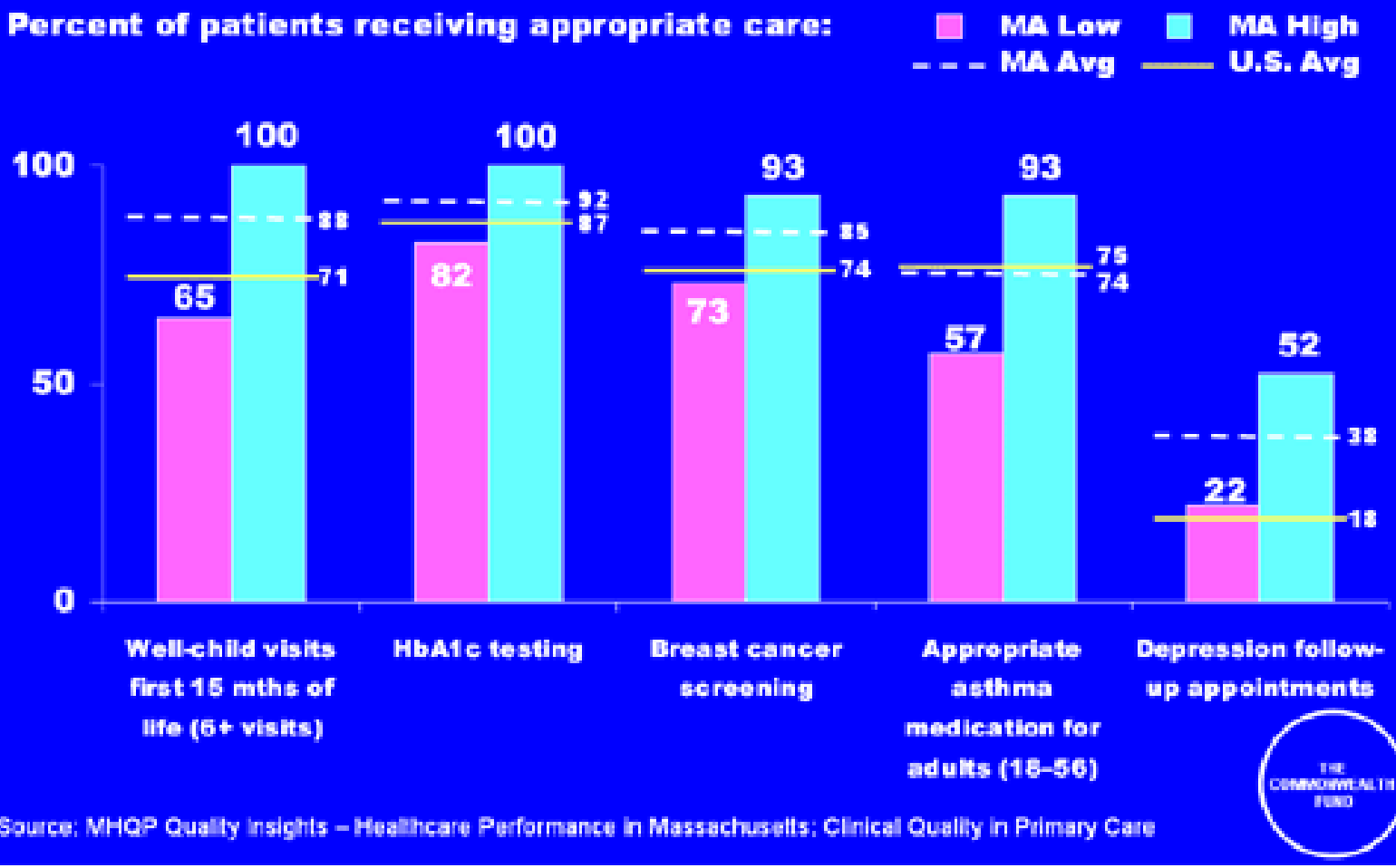



Sources: Adapted from Centers for Medicare & Medicaid Services, National Health Accounts, 2005 and Midwest Business Group on Health, April 2003.




Sources: Blue Cross Blue Shield Association, "State Legislative Health Care and Insurance Issues: 2003 Survey of Plans," December 2003; The most recent data for mandates (2004 and 2005) was compiled by AHIP from an internal database that tracks healthcare legislation (including health insurance mandates) in each state.
Centers for Medicare & Medicaid Services. National Health Accounts. 2005.

# Quality Variation Among Physician Groups
## (Highest, Lowest, & Average Performance)




Source: MHQP Quality Insights – Healthcare Performance in Massachusetts: Clinical Quality in Primary Care